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L3: Entry 1 of 2 File: USPT Mar 18, 1997

DOCUMENT-IDENTIFIER: US 5613072 A
TITLE: System for funding future workers compensation losses

US Patent No. (1):
5613072

Detailed Description Text (19):
Since the data in the claim records comprising the initial analysis ready data set are taken from claims administered by the carrier over the most recent 10-year period, the various monetary amounts paid out on those claims are a result, to a significant extent, of inflationary factors. For example, a claim for an injury which occurred in 1980 would have significantly less paid out amounts than an otherwise identical claim which occurred in 1989. Thus, in order to obtain accurate cost predictions for claims (duration is not effected by inflationary factors), all cost values for the claims in the various claim record sets must be deflated so as to represent the respective costs of each claim as if each claimed injury occurred in the first year of the 10-year claim sample period. Thus, if claim records for injuries occurring for the period 1980 to 1989, inclusive, are used by the program in creating a statistical model, then the costs incurred on each claim must be deflated to yield corresponding 1980 dollar values. In this regard, the Consumer Price Indexes are used to determine appropriate inflation, and hence deflation, values for each appropriate year during the 10-year claim sample period. Inflationary statistics used may be those representing nation-wide inflation or only state-wide inflation, depending upon the desired model application. In most cases, the inflation indexes for the state in which the carrier conducts its business is used, thereby obtaining more reliable cost predictions for that particular carrier's workers' compensation claims.

Detailed Description Text (44):
In order to appropriately apply the respective models to the data contained in claim records during the prediction process in the ultimate application of the program, the predicted cost values (in base year dollars, e.g., 1980) must be reinflated to current dollar values once they have been determined. Since the predicted cost values are all determined as if each subject claimed injury occurred in the first year of the subject 10-year sample period (for example, 1980 where the period is 1980-1989), each resulting cost prediction must be reinflared a minimum of 10 years to obtain present day dollar values. To this end, all predicted dollar values are inflated to present day dollar values using the identical publicly available medical, health, and workers' compensation cost indexes (e.g., CPI) which were previously used to deflate the claim dollar values to the first year of the claim sample period.

Detailed Description Text (51):
The three INJURY TYPE models are used both to predict the future costs incurred on new workers' compensation claims, as well as to update and/or revise predictions on previously analyzed claims. With respect to new claims, the insurance carrier enters, via its own host computer, and in the course of its own administrative record-keeping, all the pertinent data for those claims into claim records. These records are stored in data files on the host computer. The claim record is preferably stored in the form of data fields standard in the insurance industry and which closely correspond to data fields or variables recognized and used by the program on the dedicated PC. In this manner, the insurance carrier may easily provide the required claim information to the system, as described above, for cost and duration predictions using the models. Once a new claim has been entered by the insurance carrier into a claim record on the host computer, a Total Cost Incurred prediction and duration prediction for that workers' compensation claim will be obtained via the appropriate model the next time the dedicated PC is accessed by the insurance carrier. When this is done, the Total Cost Incurred prediction and duration prediction is obtained for each active claim in the

manner previously described.

Detailed Description Text (53):
The present system includes a means for adjusting the predicted reserve amounts in accordance with carrier experience and preference. For groups of claims having like injury years, the insurance carrier may enter into the system a Reserve Adjustment Factor. The Reserve Adjustment Factor is a multiplier or percentage specified by the insurance carrier to be added to each claim in the designated claim group or groups. This multiplier is adjusted on the total reserve amount ultimately calculated for claims in the designated group. For example, if a carrier has reason to believe that a given group of claims having a like injury year is likely to incur greater than normal costs, or if the carrier wishes to pad the reserve amount for those claims as a safety margin, then the carrier might enter a Reserve Adjustment Factor for that claim group of, for example, 1.25. This Factor will act as a multiplier to the total calculated reserve amount such that the reserve amount is increased by 25% for that claim. Reserve Adjustment Factors may be entered or updated by the carrier at any time by accessing the system on the dedicated PC.

Detailed Description Text (64):
Next, in a process step 335, for claims involving permanent disability (INJURY TYPE=3 or 4), the system determines whether the predicted Indemnity Incurred cost is sufficient to meet minimum statutory indemnity requirements for that claim. In this regard, most states have minimum statutory requirements for indemnity payments to workers' compensation claimants suffering permanent disabilities. For example, .sctn. 4658 of the California Labor Code sets forth in detail the payments to be made to a permanently disabled claimant in California, and also sets forth the amount of time or period during which such payments are to be made. The amount of time for which such payments must be made to the claimant are determined based on a Permanent Disability Percentage ("PDP"). The PDP is a standardized quantitative representation of the severity of a claimant's permanent injury. More specifically, the PDP is the relative amount which the claimant is deemed to be permanently disabled wherein 100% represents a total permanent disability and 0.25% represents a minimum permanent disability. The percentage of permanent disability is normally determined by claim examiners based upon a review of medical reports from treating or evaluating physicians who give opinions on what disability the injured claimant has suffered. In determining the Permanent Disability Percentage, factors which are taken into account include the nature of the injury or disfigurement, the occupation of the injured employee, the injured's age at the time of injury, and the degree to which the injury diminishes the employee's ability to perform his or her job or compete in an open labor market. Once a PDP percentage has been established, the minimum indemnity to which the workers' compensation claimant is entitled may be precisely determined by application of the specific terms of the statute (e.g., Cal. Labor Code .sctn. 4658).

Detailed Description Paragraph Table (1):
CLAIM NUMBER claim number identifying the claim record; DATE OF INJURY date the injury occurred; CLASS CODE standardized classification code designating injured worker's job industry; BODY PART industry standard body part injury code; NATURE OF INJURY industry standard code for nature of injury, e.g., burn, sprain, fracture, etc.; CUMULATIVE TRAUMA boolean variable designating whether injury is non- traumatic and occurs over a period of time; DATE OF BIRTH the birth date of claimant; CLAIM STATUS status of claim, i.e., open, closed or resolved; DATE CLAIM CLOSED date claim was closed; DATE CLAIM RESOLVED date claim was resolved; REOPENED CLAIM boolean variable indicating whether claim was closed and subsequently reopened; INJURY TYPE injury type under standard classification system (see discussion below); LITIGATED boolean variable indicating whether claim was litigated; AWARD TYPE type of award ultimately resulting from settlement of claim where: compromise and release = 1, findings and award = 2, stipulated award = 3, dismissal or take nothing = 4, and other = 5; VOC REHAB boolean variable indicating whether vocational rehabilitation costs were incurred; EMPLOYER'S LIABILITY boolean variable indicating whether employer's liability was involved; TEMP DIS INCURRED total temporary disability charges incurred; PERM DIS INCURRED total permanent disability charges incurred; TOT IND INCURRED total indemnity incurred on claim; V.R. EVAL INCURRED vocational rehabilitation evaluation expenses incurred; V.R. DIS INCURRED vocational rehabilitation disability expenses incurred; V.R. TRAIN INCURRED vocational rehabilitation training expenses incurred; TOTAL V.R. total vocational rehabilitation expenses incurred; TOTAL MEDICAL total medical costs incurred; TOTAL ALLOCATED total allocated loss expenses incurred; TOTAL SUBRO total subrogation recoveries for claim; ZIPCODE claimant's zip code; P.D. RATE weekly permanent disability rate; and T.D. RATE weekly temporary disability rate.

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L3: Entry 2 of 2 File: USPT Dec 4, 1990

DOCUMENT-IDENTIFIER: US 4975840 A
TITLE: Method and apparatus for evaluating a potentially insurable risk

US Patent No. (1):
4975840

Detailed Description Text (64):
Referring now to FIG. 6, each problem in a particular case is considered on an individual basis. Underwriting knowledge base 24 is first checked for the existence of an expert module (block 90). If an expert module is available, it is used for underwriting the subject problem unless the underwriter is rated as an expert underwriter with regard to the subject problem, in which case the system provides the underwriter an option to override the expert module (block 92). If the underwriter cannot override the expert module, or if a qualified underwriter chooses to use the expert module to underwrite the problem (block 94), the system proceeds with underwriting using the expert module (block 96). For purposes of illustration, an expert module used when the initial underwriting process indicates that the applicant participates in mountain climbing activities is illustrated by the flow charts of FIGS. 8-10. Referring to FIG. 8, the expert module first determines whether the proposed insured is ratable for a medical impairment. If so, the system recommends that coverage be declined, pending submission of the case for special consideration. If the proposed insured is not ratable for a medical impairment, the system determines whether the proposed insured is ratable for alcohol or illicit drug use, or a relevant driving history. If so, the system recommends that coverage be declined. If not, the system inquires as to where the proposed insured intends to climb. If unknown, the system requests that this information be obtained via a mountain climbing questionnaire. If climbing is to be done in locations other than North America, coverage is declined If climbing is to be done in the U.S.A. only, the system inquires as to how long the proposed insured has been mountain climbing. If unknown, use of the mountain climbing questionnaire to obtain this information is recommended. If the proposed insured has been climbing for less than two years, a rating for mountain climbing of, for example, $3.50 per $1,000 requested coverage is recommended. If the proposed insured has been climbing for more than two years, no additional premium related to mountain climbing is required After making the latter two determinations, the system branches to FIG. 10 wherein it is determined if the proposed insured climbs more than six times per year. If not, the previously determined rating is displayed on the basic rating screen. If yes, an additional factor of $2.50 per $1,000 is added to the previous rating for mountain climbing, prior to display of the basic rating screen.

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L1 and (tim$3 or period$6) same (injur$3 or disable or disabilit$3 or impair$6) same (progress$6 or successiv$4 or gradual$2)	0

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DATE: Thursday, June 12, 2003 Printable Copy Create Case

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L2	L1 and (tim$3 or period$6) same (injur$3 or disable or disabilit$3 or impair$6) same (progress$6 or successiv$4)	0	L2
L1	(4975840 or 6223164 or 5613072).pn.	3	L1

END OF SEARCH HISTORY

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L8: Entry 4 of 4 File: USPT Sep 21, 1999

DOCUMENT-IDENTIFIER: US 5956687 A
TITLE: Personal injury claim management system

Detailed Description Text (9):
Information available at stage 114 is entered into the client's data record via one or more of input devices 40. Stage 114 corresponds to a time period during which the client is receiving medical treatment for the injury. Because the extent and cost of the injury is not yet known, negotiation of the client's claim with the party that caused the injury generally does not commence during stage 114. However, information concerning the event that caused the injury, such as a slip and fall or an automobile accident, may be gathered. Also, the attorney preferably checks on the treatment progress of the client and educates the client as to the personal injury claim process.

Detailed Description Text (10):
Upon release of the client from medical treatment, stage 116 is initiated. Although some information concerning the scope and nature of the personal injury claim is gathered during stages 112 and 114, stage 116 focuses on obtaining information specific to establishing a fair compensation amount for the client. For example, medical provider records and bills, and information concerning economic loss, such as lost wages, are gathered in stage 116. Once the appropriate information is gathered, it is presented in a persuasive letter to the person who caused the injury (the defendant), the defendant's representative, or the defendant's insurance company. This "demand letter" proposes an amount of compensation needed to settle the client's claim, initiating a negotiation phase of the case. In contrast, stages 112, 114, and 116 correspond to a pre-negotiation period of the client's claim. Notably, stage 116 is still a part of pre-negotiation, but is also given the more specific designation of "Demand in Progress."

Detailed Description Text (78):
Control then flows to operation 232 where the program times a total of 30 days from the anchor 2 date. At the 30 day mark, operation 232 prompts generation of a letter to the client inquiring into the physical condition of the client and to determine if the client has changed medical providers. Conditional 234 follows, which prompts the determination of whether the attorney's representation has been acknowledged by the party receiving the notice in either operation 206 or operation 208. If not, then conditional 236 determines if there is an insurer for the defendant. If the defendant does not have insurance, then a second letter to the defendant is prompted in operation 238. If the defendant is insured, then a second letter to the insurance representative is prompted in operation 240. Control flows to conditional 242 from operations 238, 240 which again prompts to determine whether evidence has been received from the client. If evidence has not been received, then another evidence request letter is prompted in operation 244. It should be understood that such additional request letters are automatically customized to list only those evidence items that have not yet been marked as received from the client in the corresponding client record.

Detailed Description Text (79):
Referring to FIG. 3C, conditional 246 is next encountered, which again prompts whether the witness questionnaire has yet been received. If the questionnaire has not been received, then operation 248 prompts the generation of a second questionnaire request letter. Operation 250 is next encountered, which waits until 45 days lapse from the anchor 2 date before taking action. Once the 45 day period has lapsed, operation 250 prompts a letter to the client reminding the client to continue medical treatment. Also, a conditional to determine acknowledgement of representation is again encountered

in conditional 252. If there is not acknowledgement, then conditional 254 tests whether the defendant is insured. If not insured or otherwise represented, another letter to the defendant is prompted in operation 256. If the defendant is insured, then operation 258 prompts generation of another letter to the representative.

Detailed Description Text (80):
Operation 260 is next encountered which times the lapse of 60 days from the anchor 2 date, then prompts a letter to the client inquiring into the client's medical condition and whether any change in medical providers has occurred. Referring to FIG. 3D, conditional 262 is then encountered which prompts to determine whether representation has yet been acknowledged. If there has been no acknowledgement still, then conditional 264 tests whether the defendant is insured or has other representation. If the defendant is not represented, then the attorney is prompted to telephone the defendant in operation 266. If the defendant is represented, then the attorney is prompted to call the representative in operation 268.

Detailed Description Text (82):
Anchor 3 is initiated with the release of the client from medical treatment, and is set to the client's medical release date, corresponding to stage 116 of process 110 (see FIG. 2). Scheduling routine 300 of FIGS. 4A and 4B details the operation of anchor 3. Routine 300 begins with operation 302 which prompts generation of a letter to the client for an inventory of the client's medical treatment during anchor 2. A request for a copy of medical records of known medical providers is also prompted in operation 302. Conditional 304 is next encountered which prompts the determination of whether the client missed work as a result of the injury. If work was missed, then operation 306 prompts a request to the client's employer for a statement of the client's lost wages. Control flows to conditional 308 which tests whether the client's injury was of a serious nature. If the injury was serious, then a narrative from one or more medical providers is prompted in operation 310.

Detailed Description Text (84):
Referring to FIG. 4B, conditional 322 is encountered at the 20 day point. Conditional 322 prompts to determine whether medical records have yet been received. If the medical records have not been received, then operation 324 prompts a second request letter to the medical providers who have not responded. Conditional 326 is also encountered at the 20 day point to follow-up on the lost wages statement requested in operation 306. Control then flows to block 330 where the program times a total lapse of 30 days from the anchor 3 date. Conditional 332 is next encountered which prompts the determination of whether the medical records requested in operations 302, 316, 324 have yet been received. For records not yet received, a request is prompted in operation 334. Conditional 336 inquires again into whether the lost wages statement has yet been received from the employer as requested in operations 306, 328. If not received, another request for the lost wages statement is prompted in operation 338. The operations of routine 300 and anchor 3 are then complete.

Detailed Description Text (105):
At 60 days before trial, as represented by block 612, conditional 614 prompts the determination of whether motions in limine have been filed. If motions in limine have not been filed, then mailing of the motions is prompted in operation 616. Next, operation 618 is encountered wherein completion of formal discovery is prompted. In addition, operation 618 prompts preparation and delivery of an affidavit to one or more medical providers to be executed and returned for presentation as evidence during trial. In block 620, time lapses until 35 days before trial when conditional 622 prompts to determine whether all outside information needed for trial has been received. If information is missing, completion of discovery is prompted in operation 624. At the 35 day point, operation 626 prompts the preparation of final witness and exhibit lists.

Current US Original Classification (1):
705/1

Current US Cross Reference Classification (1):
705/2

Current US Cross Reference Classification (2):
705/3

Current US Cross Reference Classification (3):
705/4

Current US Cross Reference Classification (4):
705/7

Current US Cross Reference Classification (5):
705/8

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Search Results - Record(s) 1 through 4 of 4 returned.

☐ 1. Document ID: US 20020035486 A1

L8: Entry 1 of 4 File: PGPB Mar 21, 2002

PGPUB-DOCUMENT-NUMBER: 20020035486
PGPUB-FILING-TYPE: new
DOCUMENT-IDENTIFIER: US 20020035486 A1

TITLE: Computerized clinical questionnaire with dynamically presented questions

Full | Title | Citation | Front | Review | Classification | Date | Reference | Sequences | Attachments | Claims | KWIC | Draw Desc | Image

☐ 2. Document ID: US 6499658 B2

L8: Entry 2 of 4 File: USPT Dec 31, 2002

US-PAT-NO: 6499658
DOCUMENT-IDENTIFIER: US 6499658 B2

TITLE: Multiple-casualty incident patient tracking

Full | Title | Citation | Front | Review | Classification | Date | Reference | Sequences | Attachments | Claims | KWIC | Draw Desc | Image

☐ 3. Document ID: US 6305605 B1

L8: Entry 3 of 4 File: USPT Oct 23, 2001

US-PAT-NO: 6305605
DOCUMENT-IDENTIFIER: US 6305605 B1

TITLE: Multiple-casualty incident patient tracking

Full | Title | Citation | Front | Review | Classification | Date | Reference | Sequences | Attachments | KWIC | Draw Desc | Image

☐ 4. Document ID: US 5956687 A

L8: Entry 4 of 4 File: USPT Sep 21, 1999

US-PAT-NO: 5956687
DOCUMENT-IDENTIFIER: US 5956687 A

TITLE: Personal injury claim management system

Full | Title | Citation | Front | Review | Classification | Date | Reference | Sequences | Attachments | KWIC | Draw Desc | Image

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L6 and ((705/$).ccls.)	4

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L7	L6 and (705/$).pn.	0	L7
L6	L5 and (assess$6 or determin$6) same medical$3 same condition$	263	L6
L5	(tim$3 or period$6) same (injur$3 or disable or disabilit$3 or impair$6) same (progress$6 or successiv$4 or gradual$2)	4617	L5
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L4	L1 and (tim$3 or period$6) same (injur$3 or disable or disabilit$3 or impair$6) same (progress$6 or successiv$4 or gradual$2)	0	L4
L3	L1 and (tim$3 or period$6) same (injur$3 or disable or disabilit$3 or impair$6)	2	L3
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L1	(4975840 or 6223164 or 5613072).pn.	3	L1

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